The Hilltop Institute

analysis to advance the health of vulnerable populations

Adverse Selection

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Excerpts from Anthony M. Tucker, PhD
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Adverse Selection

- Adverse selection occurs whenever individuals make insurance purchasing decisions – based on their own perceived need for health services – that distort otherwise random insurance coverage risks.
- Insurers use a variety of mechanisms to mitigate against adverse selection, including underwriting, pricing, benefit design, network characteristics, and administrative rules.
- Adverse selection is of particular concern in the development of the Exchange system because of its potential to undermine the viability of Exchanges' operations.
- Maryland's Exchange Board – in concert with other policymakers such as the state Legislature and the Maryland Insurance Administration (MIA) – must identify the sources of adverse selection and consider what market rules are needed to mitigate its effects, including whether those rules should be the same inside and outside the Exchange.

Related ACA Regulation

- While federal regulations regarding some key issues (such as the essential benefit package) remain to be finalized, recent guidance does outline a basic framework to mitigate whatever residual adverse selection effects will remain once basic operating rules for the Exchanges are established.
- That framework includes a combination of short-term measures that apply during the initial transition to Exchange operations in order to limit and share overall financial risk among carriers operating within the Exchange, as well as requirements for ongoing risk adjustment of health program payments more broadly.

Related ACA Regulation: Reinsurance

- Reinsurance is a mechanism that insurers often use to limit their own risk in some way. An insurer can reinsure selected incidences of risk (e.g., high insurance claim costs for individual cases) or a book of business (e.g., total claim costs for an insurance product), and associated costs above a defined threshold dollar amount may or may not be shared between the insurer and the reinsurer.
- The reinsurance program established under the ACA will address individual high-cost cases in order to provide insurers with greater payment stability during the first three years of Exchange operations (2014-2016).
- The reinsurance program will be operated by each state with an Exchange. All health insurance issuers and third-party administrators on behalf of self-insured group health plans will make contributions to a nonprofit entity designated by the state to support reinsurance payments to individual market issuers that cover high-cost enrollee claims. States are afforded considerable flexibility in determining the details of the program beyond that basic structure.

Related ACA Regulation: Risk Corridors

- The risk corridor program is also conceived as a temporary way to share overall financial risk within the changing insurance market. However, in this case, the risk is defined relative to allowable costs at the health plan level, and that risk is shared between the federal government and qualified health plans.
- Between 2014 and 2016, HHS will administer the program whereby qualified health plans with costs that are at least 3% less than their projected allowable costs will remit charges to HHS for a percentage of those savings; qualified health plans with costs greater than 3% of their projected allowable costs will receive payments from HHS to offset a percentage of those losses.
- The states are not directly involved in the administration of this aspect of market reform, although both reinsurance and locally administered risk adjustment will be applied before consideration of the risk corridors.

Related ACA Regulation: Risk Adjustment

- Risk adjustment, in the context of the ACA, is a process through which health plan payments are adjusted for the actuarial risk of providing services.
- Health plan payments for non-grandfathered plans – both inside and outside the Exchange – will be adjusted on a budget-neutral basis to account for actuarial risk differences, and enrollment in covered plans will be treated as *one statewide risk pool*.
- HHS will establish criteria and methods for risk adjustment, likely to be analogous to diagnosis-based methods used under Medicare Advantage.
- States will be able to use qualified alternative methods and, although the ACA leaves open whether risk assessment will be administered at the federal, state, or health plan level, current guidance suggests that states should administer risk adjustment because of their role in collecting and distributing payments across plans.
- Data requirements and methods of collection and administration need to be defined.

About The Hilltop Institute

The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) is a nationally recognized research center dedicated to improving the health and wellbeing of vulnerable populations. Hilltop conducts research, analysis, and evaluations on behalf of government agencies, foundations, and nonprofit organizations at the national, state, and local levels.

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